STATE OF RHODE ISLAND
DEPARTMENT OF HEALTH
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN THE MATTER OF IRA H. ASHER, MD **C09-774**
LICENSE NUMBER MD 05145

CONSENT ORDER

The Board of Medical Licensure and Discipline, (hereinafter, "Board") received notice from the Office of Facility Regulation relating to a wrong site surgical procedure performed by Ira Asher, MD (hereinafter, "Respondent"). The matter was referred to the Investigating Committee (hereinafter, "Committee") for review and recommendation. The following are the findings of fact and conclusions of law of the Committee:

Findings of Fact and Conclusions of Law

1. The Respondent is a physician who has been licensed to practice medicine, license number MD05145. He is a 1971 graduate of Yeshiva University Albert Einstein College of Medicine. The Respondent is Board Certified in Ophthalmology.
2. Respondent practices at South Country Eye Physicians & Surgeons, Inc., North Kingstown and Wakefield, Rhode Island, and has hospital privileges at South County Hospital and Kenty County Hospital.
3. On December 3, 2009, Respondent was scheduled to perform a cataract extraction on the *left* eye with intraocular lens implant by phacoemulsification (surgical procedure in

which an ultrasonic device is used to break up and remove cloudy lens, followed by the insertion of an intraocular lens to improve vision) on a patient.

4. Upon being admitted to the Same Day Surgical Admit Area and transferred to the holding area at South County Hospital, the patient was seen by two nurses and the anesthesiologist. Identification of the patient with confirmation of he surgical procedure, side, and site was completed. Prior to operation, a "Time-Out" (Final verification of patient name and surgical site and procedure) was completed correctly, according to hospital procedure, with Respondent, anesthesiologist, and preoperative nurse present and it was determined that the surgical site was clearly marked and visible.
5. Respondent indicated there was a ten to fifteen second delay between the "Time-Out" and the surgical procedure. Respondent proceeded to perform a retrobulbar block (procedure where anesthetic is injected to the area behind the eye to prevent movement and provide anesthesia prior to surgical procedure) on the *right* eye. The circulating nurse returned to the holding area and informed Respondent he had performed the retrobulbar block on the incorrect eye. Respondent immediately stopped and proceeded to anesthetize the correct *left* eye and proceeded with the planned cataract surgery on the correct eye.
6. The patient did not present any complications post-operation and was discharged home the same day.
7. The Investigating Committee found that proper attention was not paid to the patient, resulting in a wrong site surgery. The Committee concluded that the this constituted unprofessional conduct on the part of Respondent, pursuant to R.I.G.L. 5-37-5.1.

The Parties Agree as Follows:

Based on the foregoing findings of fact and conclusions of law by the Committee, the parties agree as follows:

a. Respondent submits to the jurisdiction of the Board.

b. Respondent acknowledges and hereby waives:

   1. The right to appear personally, by counsel, or both before the Board;
   2. The right to produce witnesses and evidence on his behalf at a hearing;
   3. The right to cross examine witnesses;
   4. The right to have subpoenas issued by the Board;
   5. The right to further procedural steps except as specifically contained herein;
   6. Any and all rights of appeal to this Consent Order;
   7. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review;
   8. Any objection to the fact that it will become necessary for the full Board to become acquainted with all the relevant information pertinent to this matter in order to review this Consent Order adequately;
   9. Any objection to the potential for bias against the Respondent that might occur as a result of presentation of this Consent Order

c. Acceptance of this Consent Order constitutes an admission by the respondent to the findings of fact made by the Committee.

d. This Consent Order shall become part of the public record once it has been accepted by all the parties.

e. Failure to comply with the terms of this Consent Order, when accepted and signed, shall subject the Respondent to further disciplinary action.

SANCTION

The Respondent hereby consents to a reprimand. The Respondent is also ordered to pay an administrative fee of Five Hundred ($500.00) Dollars within 60 days of ratification of this order.

Signed this 23 day of March, 2011.

Ira H. Asher, M.D.

Ira H. Asher, M.D.

Ratified by the Board of Medical Licensure and Discipline at a meeting held on April 13, 2011.

Interim Director of Health